Reset

The STANDARD INSURANCE

State of Arizona
Waiver of Premium Continued Life Insurance
Employer's Statement

Standard Insurance Company, Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel

EMPLOYEE

Name of Employee: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Job Title: _____

Social Security No.: _____ Date of Birth: _____

WORK STATUS INFORMATION

Employee's employment status on date disability commenced _____ Employee's insurance effective date _____

Was employee actively at work the day before disability commenced? ☐ Yes ☐ No If yes, please list the number of hours worked per week _____ and the last day of work before disability commenced. _____

Has job been modified or hours reduced due to illness or injury prior to last day of work? ☐ Yes ☐ No

Is employee terminated? ☐ Yes ☐ No If yes, please list the effective date of termination _____. (**Note: If yes, please stop premium payments for this employee.**)

Reason for termination: _____

If premiums have already been terminated, please provide date premiums have been paid through: _____

Date of employment or association membership (union or other): _____ Name of union if applicable: _____

Contact person: _____

OTHER INFORMATION

A. Carrier

Does employee have any of the following insurance with Standard Insurance Company or with another carrier?

Long Term Disability **The Standard** ☐ Yes ☐ No **Other Carrier** ☐ Yes ☐ No **Applied** ☐ Yes ☐ No **Receiving** ☐ Yes ☐ No

If The Standard is the carrier, please list the policy number: _____ If the policy has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

Short Term Disability **The Standard** ☐ Yes ☐ No **Other Carrier** ☐ Yes ☐ No **Applied** ☐ Yes ☐ No **Receiving** ☐ Yes ☐ No

If The Standard is the carrier, please list the policy number: _____ If the policy has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

Life Insurance **The Standard** ☐ Yes ☐ No **Other Carrier** ☐ Yes ☐ No **Applied** ☐ Yes ☐ No **Receiving** ☐ Yes ☐ No

If The Standard is the carrier, please list the policy number: _____ If the policy has class numbers, please provide the employee's class number: _____

If there is a carrier other than The Standard, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

B. Worker's Compensation Carrier: Has employee applied? ☐ Yes ☐ No Is employee receiving? ☐ Yes ☐ No If yes, please complete the following.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ FAX: (_____) _____

Contact person _____ Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

C. Social Security Benefits: Has employee applied for benefits? ☐ Yes ☐ No Is employee receiving benefits? ☐ Yes ☐ No

Standard Insurance Company
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel

State of Arizona
Waiver of Premium Continued Life Insurance
Employer's Statement

Amount of Basic Life Insurance with The Standard $ _____

Amount of Voluntary Life Insurance with The Standard $ _____

Amount of Additional Life Insurance with The Standard $ _____

Does employee have life insurance for dependents under your group policy? ☐ Yes ☐ No

If yes, amount of Spouse Life Insurance $ _____ , Dependent Life Insurance $_____

PLEASE CONTINUE PAYMENT OF PREMIUMS UNTIL OTHERWISE NOTIFIED UNLESS EMPLOYEE HAS BEEN TERMINATED.

EARNINGS

Please check appropriate box and fill in the amount of salary.

☐ Basic Monthly Earnings Monthly rate $ _____

☐ Basic Yearly Earnings Annual rate $ _____

☐ Basic Contract Earnings Contract amount $ _____ Length of contract _____

☐ Basic Weekly Earnings Weekly rate $ _____

☐ Basic Hourly Earnings Hourly rate $ _____

☐ Commissions (Please attach list of commissions paid for the period specified in your group policy.)

Date of last increase _____

Earnings prior to increase _____ per _____

If effective date of increase in insurance is different from date of last increase, please give effective date of increase _____

AUTHORIZED EMPLOYER REPRESENTATIVE COMPLETING THIS FORM (Please Print or Type)

Employer: _____ Representative: _____

Address: _____ Zip Code: _____

Policy No.: _____ Phone No.: (_____) _____

Fax No.: (_____) _____

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on the following page of this form.

Signature _____ Date _____

Title _____

IMPORTANT NOTICE

Attachments

Please attach the following.

a. **Original** Enrollment card and all subsequent coverage selections or changes

b. **Original** Beneficiary designations and subsequent changes

c. Copy of Job Description

d. Copy of Employment Application or Resume

The STANDARD INSURANCE

State of Arizona
Waiver of Premium Continued Life Insurance
Claim Form Fraud Notice

Standard Insurance Company, Employee Benefits – Waiver of Premium
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER APPLICANTS AND CLAIMANTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Print